

1
one

WELCOME

ABOUT YOU

Today's Date: ___ / ___ / ___ File #: _____

Patient Name: _____
LAST FIRST MI

What You Prefer To Be Called: _____ Male Female

Birthdate: ___ / ___ / ___ Age: _____ SS#: _____

Mailing Address: _____

CITY STATE ZIP

Home Phone #: _____

Work Phone #: _____ Ext: _____

Other Phone #s: _____

E-Mail Address: _____

Referred By: _____

Employer: _____ How Long? _____

Employer's Address: _____

CITY STATE ZIP

Occupation: _____

Status: Minor Single Married Divorced Separated Widowed

Spouse's Name: _____

Do you have children? Yes No How many? _____

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two

INSURANCE INFO

Co. Name: _____

Address: _____

CITY STATE ZIP

Phone #: _____

Insured's ID#: _____

Group # (Plan, Local, or Policy #): _____

Insured's Name: _____

Relation: _____ Date of Birth: ___ / ___ / ___

Insured's Employer: _____

Please inform front desk of 2nd. Insurance source.

REASON FOR VISIT

The reason for this visit is a result of (*Please circle*): work, sports, auto, trauma or chronic.

(*Explain what happened*): _____

Please describe the pain & its location: _____

When did condition begin? ___ / ___ / ___

Is this condition getting worse? Yes No Constant Comes and goes

Is this condition interfering with your (*Please Circle*): work, sleep, or daily routine.

If so, please explain: _____

Have you had this or similar conditions in the past? Yes No

If so, please explain: _____

Have you been treated by a Medical Physician for this condition? Yes No

If so, where? _____

Have you ever been treated by a Chiropractor before? Yes No

If so, whom? _____ Phone#: _____

3
three

PLEASE CONTINUE ON BACK

four

IN EVENT OF EMERGENCY

Who should we contact? _____
 Relation: _____
 Home Phone #: _____ Work Phone #: _____
 Who is your Medical Doctor? _____ Phone #: _____

HEALTH HISTORY

Are you taking any of the following medications?

- Nerve pills Pain killers (including aspirin) Muscle relaxers Stimulants
 Blood Thinners Tranquilizers Insulin Other(s) _____

Do you have or ever had any of the following diseases or conditions?

- | | | |
|---|--|--|
| <input type="checkbox"/> Heart Attack / Stroke | <input type="checkbox"/> Heart Surg./Pacemaker | <input type="checkbox"/> Heart Murmur |
| <input type="checkbox"/> Congenital Heart Defect | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Artificial Valves |
| <input type="checkbox"/> Alcohol / Drug Abuse | <input type="checkbox"/> Venereal Disease | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> HIV+ / Aids | <input type="checkbox"/> Shingles | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Frequent Neck Pain | <input type="checkbox"/> Emphysema / Glaucoma | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> High/Low Blood Pressure | <input type="checkbox"/> Psychiatric Problems | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Severe/Frequent Headaches | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Ulcers / Colitis |
| <input type="checkbox"/> Fainting/Seizures/Epilepsy | <input type="checkbox"/> Sinus Problems | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Diabetes / Tuberculosis | <input type="checkbox"/> Difficulty Breathing | <input type="checkbox"/> Chemotherapy |
| <input type="checkbox"/> Lower Back Problems | <input type="checkbox"/> Artificial Bones / Joints | <input type="checkbox"/> Arthritis |

Please list any other serious medical condition(s) you have or ever had:

Please list anything that you may be allergic to: _____

List previous surgeries/treatments with dates: _____

List any **past** serious accidents with dates: _____

Family Health History: _____

Do you: Take Supplements or Vitamins? Yes No / Exercise? Yes No

Are you on a special diet: Yes No / Since: ____/____/____

Do you smoke? No Yes / How Much? _____ How Long? _____

Are you wearing: Heel Lifts Sole lifts Inner soles Arch supports

What is the age of your mattress? ____ Is it comfortable? Yes No

For women: Are you taking Birth Control? Yes No

Are you Pregnant? No Yes/How long? ____ Nursing? Yes No

five

six

ACCOUNT INFO

Person ultimately responsible for account

Name: _____

Relation: _____

Billing Address: _____

CITY _____ STATE _____ ZIP _____

SSN: _____

D.L.#: _____

Work Phone#: _____

Payment method: CASH Check

Credit Card - Enter card # above (if accepted)

I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company (if offered at this office).

- We invite you to discuss with us any questions regarding our services. The best health services are based on a friendly, mutual understanding between provider and patient.
- Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, and any other expenses incurred in collecting your account.
- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider and or managed care organization, to release any information required to process insurance claims.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Signature _____ Date ____/____/____

Adult Patient Parent or Guardian Spouse